FLASHBACKS: SCENES FROM PSYCHIATRY'S REVOLUTIONS*

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At first glance, medicine and the other sciences would seem a world apart from politics. Closer inspection reveals that, in fact, they have been warily courting each other for centuries. Genetic disorders have long been one of their common concerns, and the medical theories of the day have been appropriated by rulers and lawmakers to justify national customs and public policies. During the Middle Ages epilepsy was a dread disease, and the observation that the sacred scourge ran in families seemed to justify the Scottish custom of castrating epileptic men and burying epileptic women alive with their children.

Time brought some improvement in how countries implemented their public policies, as witness the 1757 Swedish law that merely prohibited epileptics from marrying. A century later, in 1859, Darwin published his monumental work, *On the Origin of Species by Means of Natural Selection, or the Preservation of Favored Races in the Struggle for Life.* Darwin viewed survival as a measure of fitness and progress as a result of natural selection, exercised through competition. The key to social progress was control of the unfit, perhaps through sterilization, which would then provide the answer to poverty, crime, mental illness, mental defects, epilepsy, and a host of other social ills.

It would be unfair to suggest that the road to social control was trod only by politicians. Enlightened scientists, in reciprocal fashion, sought help from politicians to encourage society to conform with the best health principles of their day, just as in our day we have our advocates of low cholesterol diets, jogging, and vitamin C, our opponents of tobacco, alcohol, and coffee. Indeed, the whole field of public health depends upon just such an interdependent relationship between medicine and politics.

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By the 1970s, however, legislators and other policy makers had become almost too eager to translate medicine's "what ifs" and "maybes" into rules and certainties. During that decade they passed more laws involving medicine than in all of American history prior to 1965. Partly in consequence of that, the federal government now pays for an ever increasing portion of all health care in the United States, and it demands more and more control over what it is paying for. At the very least, the physician is likely to perceive this as an unwelcome and bothersome intrusion into his professional life. Many think it more than merely bothersome. They warn that lawyers, not physicians, will define the range of treatments that can be used with patients; that lawyers will set the criteria and standards by which physicians are to choose from the treatments allowed; that lawyers will dictate the priorities that must be assigned to different patients.

The First Psychiatric Revolution

Throughout the greater part of human history, the role of the medical man in the care and treatment of the mentally ill has actually been a minor one. The major trends in the field continue to be dominated by social philosophy, moral suasion, and belief under the guise of medicine. Eighteenth century European reforms brought drastic changes in the humanitarian aspects of confinement of the mentally ill. During that period, the overall concern for social change and social progress gave rise to a wave of optimism about the perfectability of man and his social order. That optimism extended to mental illness and expanded into the first psychiatric revolution. The programs of the asylum that came to be known as "moral treatment" during the 1840s were widely and extravagantly proclaimed. By 1870, however, those institutions had suffered a dramatic decline from reform to custodial establishments and it was clear that the optimism of the founding reformers rested on a flimsy base. State supported mental institutions deteriorated into understaffed, overcrowded places of last resort that would not again occupy a prominent role in public policy until after World War II. Only private institutions for the mentally ill continued to develop, and they often provided models of care, attention, staffing ratios, and treatment that were impossible in a public institutional setting.

Since its inception in 1906, the mental hygiene movement has continued to advocate a preventive approach which, except for birth control, remains still to be invented in the mental health field. The mental health movement offered the insight afforded by dynamic psychologies as a

remedy for whatever happened to escape the efforts of prevention. The idea that baring instinctual conflicts would remove anxiety and guilt held implications for society in general that were too much to resist, but because this involved so much doing and educating and treating, and because there were so few people to do it, it seemed only logical to involve more people and train them to become highly skilled in discrete part functions.

The Second Psychiatric Revolution

World War II intensified the search for stand-ins or extenders for physicians, and as they were found and trained they were given increasing responsibility and independence. Once the war was over, however, many psychiatrists were inclined to pursue a different direction than they had taken previously. Some were disenchanted by the inability of their dynamic insights to contain the major mental disorders that had confronted them in the armed forces. They tried to move closer to the rest of medicine. Although the actual discoveries of psychopharmacologic agents were largely serendipitous, this group ultimately built those discoveries into the second psychiatric revolution, the era of psychopharmacology. Others, under the spell of their exposure to other disciplines and systems, expanded their horizons and embraced a social and cultural orientation well outside the medical model.

More and more of the human condition became grist for the interpretative mill. To some, at least, it seemed that the fate of individual patients was to be understood in terms of cultural or societal forces rather than in terms of symptoms, syndromes, and illnesses. The whole world became psychiatry's catchment area, and for such visionaries psychiatry itself became more a partner of sociology and political philosophy and less a sister of the other branches of medicine.

Even as this new global—perhaps even intergalactic—psychiatry was devising new ways to examine the whole world, it focused its analytic eye on its own functioning. What most of us had been taught were revolutionary reforms of the past now took on a different meaning. In psychiatry we had held the foolish notion that those mental health reformers of the 1840s had rescued the mentally ill, that they had taken them out of rejecting, punitive, discriminating, and exploitative surroundings and placed them in asylums and retreats where they were protected from a hostile environment.

The Third Psychiatric Revolution

What we had failed to realize, we were told, was that, despite their humanitarian motives, those 19th century reformers had merely superimposed a different kind of pathology on the residents of their havens and retreats. We began to see that hospitalization on its own exerted a regressive pull on patients, and that it was their warehousing in remote snakepits that produced a social breakdown syndrome that could not, therefore, be blamed on whatever illness they might have. So another wave of reform engulfed us during the 1960s as nationwide programs were mounted to get patients out of state hospitals and into the community. Deinstitutionalization, normalization, and mainstreaming became the shibboleth of the day as we marched behind the banners of the third psychiatric revolution—community psychiatry.

Now how was all this possible? Technologic developments and particularly the development of psychopharmacologic agents certainly made it possible to return patients to their communities. Of equal or even greater importance, though, was the economy, for when the mentally ill were defined as disabled and thus eligible for federal support under welfare, the states leaped at the opportunity to rid themselves of the responsibility for chronic patients by discharging them. As a result, welfare and the community and the federal government would have to pick up the tab. Probably of still greater significance was a third factor, the setting of vast social change within which both the foregoing occurred.

The Rise of Consumerism

Following World War II, there developed an egalitarianism that had not been seen before in the United States, and it manifested itself in several ways. One was a questioning of political and social authority, a widespread attitude that asks, "What right have you to tell me what to do?" Behind this was a rejection of old attitudes and values, as exemplified by the sexual revolution, the various liberation movements, and disestablishmentarianism. Distrust of the establishment, which was blamed for all the things that were going wrong in the world, engendered a do-it-yourself psychology, a need to gain control and to escape the system, a desire to preserve nature and the environment at all costs.

Another part of what has been termed the consumerism movement was an assault on all class distinctions, starting as an understandable and laudable attempt to pull the underprivileged and the disadvantaged up, and

ending for some in a demand that all special rank, status, or privilege be torn down. "Entitlement" is a favorite word in this connection; for some it seems to mean, "If you can't *give* me a Rolls Royce, at least you should sell it to me at Volkswagon prices."

The government, too, started to play the entitlement game when it proclaimed that in the Great Society health is a right even though all of us shall die, and not always because an accident plucks us from a tree of perfect health, and similarly that happiness itself is a right and not just the opportunity to pursue it.

The postwar knowledge explosion that brought technologic advances also produced a learning explosion. People know more than they used to, even about technical and professional matters. As a result, they are no longer content to leave decisions about their lives and their welfare to others. Nowadays they ask, "What are you going to do *to* me, for I have a right to know in every detail and to agree or disagree with what you propose."

Of course they continue to ask, "What can you do *for* me?" but in a slightly different way. They quickly go on to say, "Nothing but the best will do!" especially if the bill is to be paid by a third party. And if the person himself has to pay, he wants to be very sure that he is getting the most for his money. Nowadays the government, trying to make good on its promise of everlasting health, finds that it is paying a large part of the nation's medical bills, and it is asking whether it is getting the most for its money. All this has led to an increasing emphasis on accountability, which the physician can readily accept in theory but which he finds in practice difficult to distinguish from intrusion, interference, and a dangerous tendency to supplant medical judgement with legalistic procedures. Once legal advocacy became the major means to achieve the ends of burgeoning consumerism, the physician found himself facing a new world of adversaries. That, combined with the continuing knowledge and technology explosion, forced him into new ways of defining and discharging his responsibilities, into considering a new kind of ethics.

I do not mean to imply that consumerism has focused exclusively on medicine. Each day we witness a multitude of adversaries in every area, claiming that theirs is the best and only way. Yet for medicine the movement has been particularly difficult. It has highlighted a host of ethical dilemmas that all physicians face. For example, now that the technology has been developed to keep the severely brain damaged alive for extended periods, medicine has had to face the awesome question of

when is death. Now that babies can be made in test tubes, equally difficult questions are certain to preoccupy us in the coming years. When is life? Is it when the manipulator mixes sperm with ovum? Or is putting only one of the gametes into the tube enough? Or could it be that buying the test tube is sufficient, given intent to go on with the process? Abortion, organ transplantation, and genetic engineering raise equally difficult questions to which we have no satisfactory answers, although society presses us to decide even as it readies itself to attack us for whatever decision we make.

Psychiatry, however, faces additional problems that differ from what the rest of medicine must deal with. For one thing, even though our patients are severely dysfunctional, often from an early age, they do not die—not, of course, that they should; the point is, rather, that as a result they come to be an increasing social and economic burden on a society that has recently become obsessed with cost consciousness.

For another, psychiatry by its very nature deals with questions of guilt and conscience, soul and mind, attitudes and values, freedom to think and to act, the relationship of individual to society. Psychiatrists deal with patients whose disorders are expressed not as an inflamed appendix but as distortions in social behavior and emotional relations. The psychiatrist must therefore deal not only with the patient's pain and distress, but also with his family's and society's attitudes and demands, including standards for employment and education, community expectations about social conformity and actions in public, and the definition of all of those in legal imperatives. Another factor is that the psychiatrist is held responsible for the behavior of his patient, even as he is accused of irresponsible interference with that patient's freedom. Finally, there is fear among many that psychotechnology may be used to gain social control with mind altering drugs, electrode implantations, psychosurgery, operant conditioning, and the like.

The Welfare And Therapeutic States

The welfare state, the *parens patriae* concept in action, began with aid to the poor and public education, then extended to assistance with housing, retirement benefits, and medical care, and now may provide universal or comprehensive health insurance and perhaps even guaranteed general subsistence. Concurrent with the development of the welfare state in this country, the criminal law system has been undergoing a gradual process of divestment, that is, of relinquishing its jurisdiction over many tradition-

al areas so that various classes of criminal offenders are no longer subject to its sanctions. These include the mentally ill, juveniles, at times alcoholics, drug addicts, and sexual deviants or variants. The sin of yore is the sickness of today. This development reflects increasing social emphasis on therapy, rehabilitation, and prevention, which is in sharp contrast to the emphasis of criminal law on retribution, incapacitation, and deterrants.

Designating undesirable conduct or even undesirable viewpoints as illness rather than as crime has been a major earmark of this century. Thomas Szasz and Ivan Illich, among others, have commented on the dangers of such medicalization of human problems, and I need not repeat their strident criticisms here. It does seem, unfortunately, that the welfare state cannot long accept a passive role of humane support for what already exists. It must eventually embark on active programs designed not only to relieve but to prevent crime, delinquency and poverty, to improve or cure the disadvantaged and the deviant. The merger of the welfare state with the reforming drive of the social and behavioral sciences has produced the therapeutic state, which turns our energies into prevention and rehabilitation.

Very often a psychiatrist is expected to deal with behavior that does not conform to a family's or a community's standards, but that is not viewed as a dysfunction by the subject. Is the subject sick or deviant or just doing his own thing? Or is his family being overdemanding and is it out of step with the times? Or is the community trying to hide its bigotry behind a smokescreen of pseudoscientific jargon and getting psychiatrists to be the "fall guy" for decisions that it is unwilling to make overtly? There is no doubt that psychiatry—or just psychological evaluation—*can* be a vehicle for assaults on people's rights. One must nonethelesss sympathize with the psychiatrist whom society pressures to control, ameliorate, or abolish nonconformity, even as it files complaints against him for doing its bidding. Our sympathy, of course, should not lull us into believing that we carry no share of the burden to question our methods or motives.

Those who might finally be labelled as patients are understandably apprehensive, since the treatment label engenders at least as much suspicion and hostility as does the criminal label. Those potential patients fear that in the name of therapy, society will impose upon them controls over their behavior that it ought have no concern about. They suspect that the therapeutic state has tools of human control far more oppressive than the sanctions possessed by the criminal model. Consider, for example, the mother on welfare. Should aid to her needy children be cut off if she has

an illegitimate baby after she has accepted welfare payments? Does the state that pays her have the right to raid her house to see if any able bodied man lives there? Can the state tell her how to spend her welfare check? Can it force her to work in order to qualify for assistance? What happens if she tries to buck the system? Will her hostility be interpreted as healthy resistance to oppression or will the examining psychiatrist, the modern day guardian of morality and the priest of the current technologic age, decree instead that her hostility is sickness or criminal? Psychiatry should continually assess the use society makes of it to preserve the status quo. Is it possible that some treatments are, in fact, used to suppress political opposition? Is it possible that sometimes, wittingly or unwittingly, the psychiatrist has in fact become an agent of social control who identifies and immobilizes those with deviant ideas in much the same way that medieval inquisitors identified and tortured witches?

Any report on how psychiatry is faring at the moment in the arena of public policy might best be entitled "Notes from the Firing Line." Although it seems that only yesterday we were riding a strong wave of acceptance and enthusiastic support, the wave appears to have broken over our failures to fulfill the expectations we had generated among our admirers. Many of yesteryear's allies seem to have become this year's adversaries, now claiming not only that they do the same things we have always thought of as our functions, but even that they do them better. The trail that we blazed through the mental health forest has become an overused expressway. We no longer enjoy exclusive rights of passage; quite the contrary, we are often challenged when we try to pass through the entrance turnstile and are asked to prove why a psychiatrist is necessary to do any of the things that have been traditional parts of our daily practice. One of the problems may be that we have no more consistency of scientific/medical support than our patients have of political support.

Often overlooked is a phenomenon endemic to American society, where competence and achievement are revered and anything less is disavowed. As Norman Dain has pointed out,[1] this has meant that mental health reformers have generally deserted the objects of their original munificence when the "saved" patients are found to remain silent and inactive, refusing to assume the power wrested for them and seemingly unable to group themselves into a dependable and identifiable constituency for their rescuers.

In the 19th century the reformer's zeal was devoted to saving people who could not protect themselves against the ravages of a predatory,

heartless, uncaring, unloving, rapacious, self-centered society by providing them havens in asylums—and thus the state mental hospital system was born. But in the 20th century this was interpreted as snatching the person away from the loving arms of his family and community, depriving him of the benefits society has devised for its members (muggings, murders, release from back wards to be knifed in back alleys), imposing a new illness (social breakdown syndrome) on him and using it as an excuse to invade his privacy, to assault his body, and to blunt or to remove his mind with treatments that did more harm than good.

While community psychiatry tried to correct this by bringing patients back into the community, their expulsion from mental hospitals was no guarantee that those people disappeared or that their illnesses had been eradicated. According to the rules of the numbers game, however (where accountability and effectiveness translate into a bureaucratic maelstrom of counting, computing, and obsessing about the irrelevant, with little regard for what happens to those being counted), they were no longer being counted as mental patients. But that is another story. In any event, I do not mean to imply that all those discharges were inappropriate. Both the reform movements alluded to—the 1840s push to get the patients into hospitals and the 1960s drive to get them out—were based both on humanitarian motives and on a body of scientific observations, but both promised more than they could deliver and neither was given a fair trial.

We have our own brands of reformers today, and they appear in two main guises. One is the antiscience theorist, who argues that since most illness is socially induced, there is at best an expensive window-dressing role for medical science in the prevention or treatment of disease; that medical intervention only upsets the natural balance which is more suitably maintained by naturopaths or other health cultists; that medicine fosters survival of the *un*fit and thereby endangers the very society it would treat; and that 20th century treatments harm more often than they help.

Not radically different in their conclusions and sometimes even more abrasive in their methods, are the second brand of reformers, the consumer advocates. They distrust the establishment, bureaucracy, and professionalism (which they view as the cornerstone of the health "industry"). In psychiatry, consumerism has focused on the issue of civil rights: the right to treatment, the right to refuse treatment, informed consent, commitment procedures, etc. Psychiatrists more and more find themselves in a novel and often conflicting relationship with lawyers, each professional

trying in his fashion to improve the lot of his patient (or client). Its main thrust is that the psychiatrist and his clinically based opinions are not to be trusted, that the patient must be protected at every turn of the road by a lawyer, no matter how costly, cumbersome, traumatic, superfluous, or irrelevant his solicitous ministrations might be. Such advocates would ignore the patient's psychiatric condition to shepherd him through a maze of adversary proceedings, court hearings, and treatment review committees that would build a system of mandated malignant neglect.[2]

The answer, of course, is not a stronger adversarial stand on one side or the other, so that one profession will emerge the victor, but rather more attempts to bridge the gap between the different conceptualizations and philosophies of the two professions. The law rests firmly on the notion of free will; psychiatry, in contrast, is primarily deterministic. The task of both professions is to forge a new coupling, to reach a compromise that will help our patients. This cannot be done overnight, obviously, and no one could doubt that we shall face a host of thorny issues on the relationship between psychiatry and the law during the coming years.

Also let no one doubt that a host of ethical issues will continue to confront us and the rest of medicine during the next few years. One we are currently struggling with is the very complex issue of privacy and confidentiality, involving both third party payors and insurance claims on the one hand and research efforts on the other. Health care today is a triangle of patient/doctor/proctor, and quite clearly the proctor will gain access to some information about the patient that heretofore only the doctor was privy to. The questions are: how much information is needed to satisfy the legitimate requests of the third party, and who will have access to it once the information has been given? We shall resist what are unnecessary, inappropriate, and perhaps illegal encroachments upon patients' rights to privacy, but we cannot say that there can be no encroachment. It is as with informed consent, but for the psychiatric researcher the shoe, this time, seems to be on the other foot, and it is the patient who is having to be told too much. The current crisis in research, particularly as it involves human subjects, is but one warning about the dangers of pushing a position to an unworkable extreme. Concern about such matters is welcome and appropriate. Any specific actions that might devolve from those concerns require deliberations and negotiations between all the conflicting interests involved.

Let me sound a note of caution about our own approach to ethical matters. Who says, for instance, that 365 days on the artificial kidney for

one life are better than giving one day of additional life to 365 different people? Who says that letting schizophrenics die on the streets or be victimized in prisons and shelters for the homeless is better than protection in an asylum? Who can say that it is good to treat depression in a 55 year old but wasteful to do the same for a 75 year old? No profession, specialty, or any of its individual practitioners should be forced to take responsibility for the decisions that society as a whole must make. Science cannot prescribe solutions to moral problems because these involve value judgments as well as estimates of reality.

Evaluation of different types of social policy and social structure can only be undertaken properly when, for instance, there are adequate measures of morbidity in patients and relatives. Administrative indices such as length of stay, staff-patient ratios, readmission rate, or cost per patient are weak or valueless in themselves and may, in fact, be antitherapeutic and unethical when used only to control costs.

There has been an emphasis in many studies recently on risk factors, elements predisposing to the later development of disease. Although epidemiologic studies have often devoted themselves to identifying putative risk factors for various diseases, not even the scientific community has always been aware of the tentativeness of their implications. The demonstration of risk factors, for example, does not quantify the risk for any individual, nor is the relative importance of any one of the many assumed risk factors usually quantifiable. Further, one is rarely certain that the identified risk factors constitute the total number of factors predisposing to the disease in question. Finally, few studies of risk factors give more than fleeting recognition of possible antirisk or protection factors, whose potential for offsetting risk factors might alter profoundly the likelihood of any person or subpopulation developing the disease in question.[3]

There comes a time when reformists' zeal must be matched against available data, and, while humanistic goals may persist, the paths to them must be modified.[4] A guiding assumption of many community mental health programs is that differences between the problems of living on the one hand and the psychoses on the other are quantitative, not qualitative. Another widely held belief is that intervention in the early stages of disease can prevent disability. Mechanic[5] has called attention to the conjectural nature of these assumptions and to the growing body of evidence to the contrary. An impressive body of data gained over time and across cultures regarding rates of psychoses and on concordance and consanguin-

ity in schizophrenia and manic depressive psychosis, testifies against the idea of a simple behavioral continuum of psychopathology and against the belief that treatment intervention and policy formulations can be meaningfully addressed in a nonspecific global manner.

One of the main findings of reports from the United States and Europe over the past 50 years has been that age corrected risk figures for properly grouped relatives of schizophrenics have invariably been many times higher than for unrelated contemporaries in the general population. Because of these findings, many believe that at least one of the essential requirements for the development of clinical manifestations of the schizophrenias is a genetically determined disorder of metabolism or, at least, some kind of inborn physiologic defect. Attempts to isolate and to identify the nature of that defect have constituted a recurrent theme of American and European psychiatry throughout this century.[6] While it may be that many factors interfere with reproduction rates in schizophrenics, it must nonetheless be recognized that studies already reported indicate that these factors alone will not hold the disorder in check. Kallmann and his associates, for instance, found many changes in the 1954-56 sample of hospitalized patients as compared with the 1934-36 sample. More were married, there were more offspring of dual matings, and there was more involvement of the offspring and their families with social agencies—and all of this had already occurred within the early years of deinstitutionalization.[7]

We still do not know the effects, relative strengths, and weaknesses upon the offspring's later behavior and performance of being removed from the care of a psychotic parent or being exposed to that parent as a function of type of parental illness, sex of the parent, length and intensity of exposure, and the critical period of maximal developmental effect on specific psychologic functions. What effects may be produced or exacerbated by such circumstances where learning and imitation are seen as of major developmental importance, where the behavioral models are distorted or defective or when the child is caught up in the emotional turbulence of major parental mental disorder?

The current policy position that institutionalization is detrimental is based upon the logical fallacy that since bad hospitals are bad for patients, any hospital is bad for any patient. Such a policy will eventually lead to the need to rediscover the public mental institution, because, unfortunately, there remain large numbers of chronically psychotic people who are unable to exist outside an institutional setting.

In this connection, it might be appropriate to point out how some of the accumulated data have been used to justify policy decisions in the area of mental health planning. To be sure, numbers are a dangerous game for nonstatisticians to play, and one puts himself at risk when he questions some generally accepted conclusions. Consider, for instance, the oft quoted figures about the movement of patients away from institutions and toward community based care—in 1955 there were almost 600,000 patients in state mental hospitals. By 1975 that number had fallen below 200,000. In 1955 77% of all patient care episodes were treated in inpatient settings and 23% in outpatient settings. By 1975 that ratio had reversed, and now three of every four patients are outpatients in public and private settings. At first reading, that would seem to be a commendation for treating patients in their communities and for intervening in such a way as to avoid hospitalization. A second glance, however, suggests that another conclusion might be just as reasonable. If one were to look at the actual number of patient care episodes, he would find that in 1955 they totalled 1.7 million. In 1975 the total was 6.9 million episodes. Of those, 1.3 million were inpatient episodes in 1955, as compared with 1.9 million in 1975. Outpatient care, on the other hand, accounted for only 391,000 episodes in 1955, but for slightly over 5 million in 1975. In other words, the quadrupling of services overall was due almost wholly to the 12-fold increase in outpatient care, which numbers did not, incidentally, include private office practice mental health professionals. Inpatient care, in contrast, rose slightly by somewhere between a factor of 1.16 to 1.47. Most interesting of all, the population also rose during that period by a factor of 1.26. It could therefore be concluded that the basic core of the severely mentally ill had remained fairly constant through the years, and that the large increase in patient care episodes was a result of the expanding definition of illness. Which of those conclusions you (or your congressman or your local health planner) accept is of no mean import, particularly when one considers that the direct cost of providing those services increased 10 times during that period—from 1.7 billion dollars in 1955 to 17 billion dollars in 1975.

At the present time, however, the patient is regarded as best treated outside of any institution and within the setting that is presumed to have induced or contributed to his illness. The continuing tendency is to deal with global aggregates of patients and treatments while ignoring the growing body of literature indicating the absolute imperative for reliable differential diagnoses, to guide prescription of specific therapies for specific illnesses.

Excellent studies of combined treatments in psychiatry are appearing, suggesting the differential value in depressions, for instance, of drugs to restore mental capacity, psychotherapy to restore social competence, and a combination of both to prevent relapse. In the long run the wrong kind of social network and familial setting may be prepotent relapse inducing factors. It is not community support itself but its specific qualities and treatments that help. Rehabilitative measures provided in a nonintensive but targeted fashion in aftercare centers may be more effective than a high intensity group therapy "push."

Planning is typically insensitive to mental health needs just as insurance and third party payors tend to discriminate against the mentally ill. In many contracts, psychiatric illness either is not covered at all or is restricted to so small an amount that it is for all practical purposes nonexistent, or requires such high copayments that what is provided can hardly be construed as a benefit. The government, the biggest payor of them all, has manifested this discrimination and insensitivity by imposing stricter regulation and ever more complicated bureaucratization on the mental health arm of medicine. It seems to idolatrize the myth of the efficient single system, the creed of counting and quantifying.

To have worked within, or even with, the state hospital system is to have been frustrated by it, and to have learned how governmental medicine replaces patient care with paperwork, counting, and a preoccupation with the letter of the law to the neglect of its spirit and intent. At every level we must press for constant questioning of the redundancies, inefficiencies, and inflexibility of bureaucracies that tend always to perpetuate themselves, of systems that can live only if they destroy the creativity and flexibility that might produce more effective and beneficial substitutes.

We espouse the authority of reason but must always repudiate the tyranny of ignorance, especially when it affects those whom no one else will defend. One reason for our nation's greatness is our sense of humanity, our determination to salvage people as productive members of society. We have always operated on the premise that those in need will receive help because it is in the common interest that they receive it. To withdraw that support is to destroy the quality of our nation and the morale of our citizenry. To fail to reward excellence and achievement is equally destructive. It is not a matter of either/or, but a need for both; we must pull collectively as a nation if we are to realize our potential.

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